

Bureau of Health Care Quality and Compliance

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3531AGC | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 12/08/2010 |
| NAME OF PROVIDER OR SUPPLIER GOOD SAM CARE HOME, INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 3226 KEMP STREET N LAS VEGAS, NV 89032 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| Y 000 | <p>Initial Comments</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of a complaint investigation conducted regarding your facility from 11/24/10 to 12/8/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons, Category I and II residents.</p> <p>The following deficiencies were identified:</p> <p>NV00026465-The allegation regarding quality of care/treatment was substantiated. See Tag Y878.</p> <p>NV00026465-The allegation regarding administration/personnel was substantiated; however there were no regulatory deficiencies identified through interview and record review.</p> <p>The investigation included:</p> <p>-Interview with Employee #3. According to Employee #3, Employee #4 was employed to clean the facility and not as a caregiver. Employee #3 stated that Employee #4 had a limited knowledge of the English language and was never left alone with the residents in the facility. Employee #3 stated that another staff member that understood English was present when Employee #4 was present.</p> | Y 000 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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| Y 000 | Continued From page 1 -Record Review-According to staffing schedules for the time period involved, other staff members are listed on the schedules and Employee #4 is not listed on the work schedules. NV00026465-The allegation regarding resident/patient/client rights was not substantiated through interview and record review. The investigation included: -Record Review-A review of the resident's admission contract does not state a refund policy for the care facility. -Interview-According to Employee #3, the care facility does not have a refund policy to her knowledge. | Y 000 | | | |
| Y 878 SS=D | 449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. | Y 878 | | | |

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| Y 878 | Continued From page 2 This Regulation is not met as evidenced by: Based on record review on 11/24/10, the facility failed to discontinue a medication (Lomotil) as ordered by a physician (Resident #1). Severity: 2 Scope: 1 | Y 878 | | | |

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